Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address:

PAMPA PHYSICAL THERAPY
2111 N HOBART
PAMPA TX 79065

Respondent Name:
STATE OF TEXAS

Carrier's Austin Representative Box
Box Number 45

MFDR Tracking Number:
M4-12-0469-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This letter is in reference to the denial of payment for treatments provided for patient [injured employee]. In a letter dated 09/27/2010, Pampa Physical therapy was given pre authorization to perform physical therapy consisting of therapeutic exercise as related to the left lower extremity. No codes were in the preauthorization letter, but it was understood that only exercise related codes would be covered."

Amount in Dispute: $570.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Preauthorization number 1064911 FO *only* authorized 6 sessions of Therapeutic Exercises which is billed under CPT code 97110 pursuant to the Healthcare Common Procedure Coding System. The preauthorization did not include authorization for Electric Stimulation as billed under CPT code G0283 and Therapeutic Activities as billed under CPT Code 97530."

Response Submitted by: State Office of Risk Management, PO Box 13777, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 27, 2010 through October 7, 2010	CPT Code G0283	$570.00	$0.00
September 27, 2010 through October 7, 2010	CPT Code 97530		

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits were not submitted by either party; however, the Respondent states in their position summary that they are maintain the denial for the above codes for 197 – Payment denied/reduced for absence of precertificiation/preauthorization.

Issues

1. Did the requestor submit the request for medical fee dispute resolution in accordance with 28 Texas Administrative Code §133.307?
2. Is the request for medical fee dispute resolution eligible for review?

Findings

Pursuant to Texas Administrative Code §133.307(c)(2)(A) the Requestor did not submit a copy of all medical bill(s), in a paper billing format using an appropriate DWC approved paper billing format, as originally submitted to the carrier and a copy of all medical bill(s) submitted to the carrier for reconsideration in accordance with Texas Administrative Code §133.250 of this chapter (relating to Reconsideration for Payment of Medical Bills) and 28 Texas Administrative Code §133.307(c)(2)(B) of this chapter relating to the requirement of submitting a copy of each explanation of benefits (EOB), in a paper explanation of benefits format, relevant to the fee dispute or, if no EOB was received, convincing documentation providing evidence of carrier receipt of the request for an EOB . In accordance with §133.307(e)(3)(I), the request for medical fee dispute resolution was not submitted in compliance with the provisions of the Labor Code and this chapter.

Conclusion

For the reasons stated above, the division finds that the request for medical fee dispute resolution is not eligible for review. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December 8, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.